Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

The Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747
Boston, MA 02114-8747

(617) 727-2310
Fax (617) 227-2681
TTY (617) 227-8583
www.mass.gov/gic

Date:
Name of Insured (and Spouse, if applicable):
Address:

GROUP *DENTAL/VISION* CONTINUATION COVERAGE UNDER COBRA ELECTION NOTICE AND APPLICATION

You are receiving this notice because the Group Insurance Commission (GIC) has been informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status.

This notice contains important information about your right to temporarily continue your Dental/Vision care coverage in the Group Insurance Commission's (GIC's) Dental/Vision plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the enclosed Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group Dental/Vision coverage if group coverage otherwise would end due to certain life events. If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit in writing at Group Insurance Commission, P.O. Box 8747, Boston, MA 02114, or by calling the Unit at 617/727-2310, ext. 1. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** for more general information about COBRA.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's Dental/Vision insurance program, you have the right to choose COBRA coverage if

- You lose your group Dental/Vision coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's Dental/Vision insurance program, you have the right to choose COBRA coverage for yourself if you lose GIC Dental/Vision coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse divorce or legally separate.

If you have dependent children of an employee covered by the GIC's Dental/Vision insurance program, each child has the right to elect COBRA coverage if he or she loses GIC Dental/Vision coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced;
- The parents divorce or legally separate; or
- The dependent ceases to be a dependent child under GIC eligibility rules.

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group Dental/Vision coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other Qualifying Events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC of the second qualifying event in writing before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days of your receiving it and before your initial 18 month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA premium is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group Dental/Vision plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group Dental/Vision coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date their group coverage otherwise would end. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable premium for your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your premium is 150% of the applicable full cost premium for the additional 11 months of coverage. Premium rates will change periodically. This year's COBRA rates accompany this notice.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

In order to cover you immediately after your current group coverage ends, your first payment pays for 'retroactive premium' you owe for the cost of COBRA coverage from the time your current group coverage otherwise would end up to the time you make the first payment. **You are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments usually are due around the 15th of each month. The GIC will send monthly bills for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After you pay for the retroactive premium payment, you will be given a 30-day grace period, beyond the due date on each monthly bill, in which to make each monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to pay the premium before the grace period for that payment ends, you will lose all rights to COBRA coverage.**

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must elect COBRA within 60 days from the date you would lose group coverage due to one of the events described above**. If you do not elect COBRA coverage within the 60-day limit, your group Dental/Vision insurance coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment of COBRA'S retroactive premium within 45 days after you elect COBRA.** If you do not make your first payment for the entire retroactive COBRA premium within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly premium for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. You will receive a monthly bill for COBRA coverage, which will specify the due date for the premium charged and the address to which payment is to be sent, If you do not pay the premium in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The employee or former employee dies;
  - The employee becomes legally separated or divorced;
  - The employee or employee's former spouse remarries;
  - A covered child ceases to be a dependent under GIC eligibility rules;
  - The Social Security Administration determines that you or the employee is disabled; or
  - The Social Security Administration determines that you or the employee is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at the Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

GIC Dental/Vision Plan Monthly COBRA Rates		
Effective July 1, 2009	Individual	Family
Dental/Vision - Indemnity Classic	$36.37	112.88
Dental/Vision - PPO Value	25.83	80.17

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DENTAL/VISION COBRA APPLICATION

For Managers, Legislators, Legislative Staff and Certain Executive Office Staff Only

Name of Applicant: _____

Home Address: _____

Social Security Number: _____

Date of Coverage Termination (if known): _____

(Check one): I am the ____ Insured ____ Insured's Dependent (spouse, child)*

(If dependent) Name of Insured: _____
Insured's Social Security Number: _____

Applicant Signature: _____ Date: _____

*all dependents **must** complete information below in order to process application

IF YOU ARE A DEPENDENT APPLYING FOR COVERAGE, PLEASE CHECK ALL THAT APPLY

___ I am a former spouse of a state insured who
- ___ died on ___/___/___
- ___ remarried on ___/___/___
- ___ left state service on ___/___/___
- ___ I remarried on ___/___/___

___ I am a surviving dependent of a deceased state insured, and remarried on ___/___/___

___ I am a dependent of a state insured and
- ___ my parent (the state insured) died on ___/___/____
- ___ my parent (the state insured) left state service on ____/____/_____ *(if known)*
- ___ my parents legally separated or became divorced on _____/_____/_____
- ___ I am age 19 to 26 and am no longer eligible for GIC coverage under the GIC's eligibility rules
- ___ I am age 26 or over and am not a full-time student

___ I am a ___ spouse or ____ dependent of a state insured and the Social Security Administration determined that I am ___ disabled or ___ no longer disabled as of ____/___/___

Mail completed form to: GIC, P.O. Box 8747, Boston, MA 02114-8747 Attention: COBRA Unit

For GIC Use Only - Do Not Write in This Space

Insured's Agency/Division: _____/_____

Coverage Information: _____ Effective Date: _____ Coverage Termination Reason:_____

COBRA Agency/Division: _____

COBRA effective date: _____ Expiration date: _____